**Performance**

**Report**

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Ozcare |
| Commission ID: | 700104 |
| Address: | 66 River Terrace, KANGAROO POINT, Queensland, 4169 |
| Activity type: | Quality Audit |
| Activity date: | 20 August 2024 to 30 August 2024 |
| Performance report date: | 14 October 2024 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

# Services included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 952 Ozcare  
Service: 18280 Ozcare - Fraser Coast  
Service: 23023 Ozcare Home Care Packages - Brisbane North Region  
Service: 23024 Ozcare Home Care Packages - Bundaberg Region  
Service: 23028 Ozcare Home Care Packages - Cairns Region  
Service: 28311 Ozcare Home Care Packages - Emerald Region  
Service: 28312 Ozcare Home Care Packages - Gladstone Region  
Service: 23029 Ozcare Home Care Packages - Gold Coast Region  
Service: 29443 Ozcare Home Care Packages - Innisfail Region  
Service: 23030 Ozcare Home Care Packages - Mackay Region  
Service: 23031 Ozcare Home Care Packages - North Lakes Region  
Service: 23032 Ozcare Home Care Packages - Rockhampton Region  
Service: 23021 Ozcare Home Care Packages - South Brisbane Region  
Service: 23033 Ozcare Home Care Packages - Sunshine Coast Region  
Service: 23034 Ozcare Home Care Packages - Toowoomba Region  
Service: 23035 Ozcare Home Care Packages - Townsville Region  
Service: 23038 Ozcare Home Care Packages - West Moreton Region  
  
Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7482 Ozcare  
Service: 24568 Ozcare - Care Relationships and Carer Support  
Service: 24569 Ozcare - Community and Home Support

**This performance report**

This performance report has been prepared by Peter Frangiosa, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the services it operates, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Quality Audit report was informed by a site assessment, observations at service outlets, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 2 October 2024

# Assessment summary for Home Care Packages (HCP)

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

# Assessment summary for Commonwealth Home Support Programme (CHSP)

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

**Requirement 1(3)(b)** - Care and services are culturally safe.

**Requirement 1(3)(e)** - Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.

**Requirement 6(3)(d)** - Feedback and complaints are reviewed and used to improve the quality of care and services.

**Requirement 8(3)(c)** - Effective organisation wide governance systems relating to continuous improvement and feedback and complaints.

**Requirement 8(3)(d)** - Effective risk management systems in relation to high-impact and high-prevalence risks and incident management systems.

**Requirement 8(3)(e)** - Where clinical care is provided - a clinical governance framework relating to minimising the use of restraint.

# Standard 1

|  |  |  |  |
| --- | --- | --- | --- |
| Consumer dignity and choice | | HCP | CHSP |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Not Compliant | Not Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Not Compliant | Not Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant | Compliant |

Findings

**Requirement 1(3)(b)** - was found non-compliant following a Quality Audit undertaken from 20 August 2024 to 30 August 2024. The service did not demonstrate:

* Care and services are culturally safe

The Assessment Team was not satisfied the provider had an understanding of what it means to deliver culturally safe care to consumers, nor, that a proactive approach is being taken to support the workforce to deliver culturally safe care to consumers. The Assessment Team provided the following evidence to support their assessment:

* 2 consumers from culturally diverse backgrounds, who are receiving care in a way which is considered culturally safe was submitted to the Assessment Team by management. However, when interviewed, both consumers confirmed their nationality, indicating this does not change how they wish their care to be delivered. These examples provided by management did not demonstrate how care is delivered in a culturally safe way and evidenced a lack of understanding of the elements of what providing culturally safe care means.
* One consumer care plan stated, ‘difficulty finding the right word’, however made no mention of a language barrier, language spoken or strategies to support staff to communicate with this consumer. The Assessment Team was of the view that this consumer was not able to fully participate in the interview due to communication barriers and may have benefitted from an interpreter service or support if outlined in the care planning documents provided to the Assessment Team.
* 22 staff were sampled for this Requirement, with the majority demonstrating they recognise and respect each consumer’s nationality. However, they could not describe how they would offer services to support each consumer’s unique cultural identity.
  + 10 staff interviewed could not describe how they adapt services offered to be culturally safe for each consumer.
  + 4 staff interviewed described how they provide culturally safe care by supporting consumers who have a language barrier, however, could not provide examples of how they provide culturally safe care.
  + 8 staff demonstrated an understanding of events or preferences which may affect what is culturally safe for different people.
* Reviewed ‘Privacy and Dignity in Care’ and ‘Professional Boundaries’ training modules did not evidence reference to diversity, culture or the delivery of culturally safe care. Furthermore, review of training records did not evidence any training module provided to staff in relation to diversity, culture, or cultural safety.

The Provider provided the following in response to the Assessment Team’s report.

* Identifying an existing Business Rule (CC082 Culture, Diversity and Inclusion) that guides staff practice in regard to Cultural Safety. We will support that guidance with a new training package with its delivery to staff conducted by our Practice Assurance role and Improvement Lead, oversighted at the service level by the respective Branch Managers and Operations Managers. This body of work will be completed by 30 November 2024.
  + This training will form part of the staff mandatory training package.
  + (20240924 Cultural Safety Education) provided as evidence in support of response to deficiencies identified.
* Review of care planning process to ensure that any client’s particular cultural needs are incorporated into the care plan so that staff are made aware of those needs.
* We note that an instance of culturally safe care was cited in the report under Requirement 2(3)(b) in regard to a client who identifies as of Aboriginal / Torres Strait heritage. It was noted that communication and advocacy from elders has been incorporated into his service, provided for an individualised approach to that client’s service delivery. In addition, we note in requirement 7(3)(a) the Assessment Team was unable to identify any instances where staff failed to show respect for consumers cultural background.
* It was noted the comment in this finding regarding a request for information regarding clients from culturally diverse backgrounds. During the course of the Quality Audit, the Head of Community Care provided data extracted from our electronic client management system, that identified particular clients with particular cultural needs. This information included those from a NESB, indigenous status, need for translators etc. This data included personal information for those clients so we will not attach it to this response, but we could provide this information if requested.
* The Assessment Team identified that the majority of staff interviewed stated that they had been provided training in relation to cultural safety.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided, including.

* The development of training material (20240924 Cultural Safety Education) in conjunction with training sessions to be delivered to all staff on Cultural Awareness and Safety (proposed date 29 November 2024), as per the services Continuous Improvement Plan (CIP).
* Training to be incorporated into Learning Library, Mandatory Training and ongoing learning pathway for Community Care staff (proposed due date as per CIP, 11 October 2024)
* Acknolwdgement of positive staff engagement regarding respect of consumers’ cultural background.

Evidence that the organisation is being responsive to cultural safety issues and supports the workforce to work in cross-cultural settings in a positive way includes managements response to the Assessment Team during the audit including.

* Upper management stated cultural safety training is not provided to staff, however advised a current project to deliver staff training on cultural safety was in progress and were unable to provide timeline for completion.
* The Assessment Team provided feedback to upper management regarding staff understanding of cultural safety, whereby management adjusted the Continuous Improvement Plan (CIP). The CIP was reviewed, which evidenced a review of policies, processes and implementation of cultural safety training to all staff with a planned completion of 30 November 2024.

The intent of this requirement is about recognising, respecting and supporting the unique cultural identities of consumers by meeting their needs and expectations and recognising their rights. An understanding of a consumer’s cultural identity can lead to better care and service outcomes for consumers. What is culturally safe for one consumer can be different to what is culturally safe for another consumer. This can be true even among people who identify as being from the same group.

I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them, however at the time of my finding, the full suite of proposed CIP actions have not been implemented or embedded. Once established and embedded, results should identify themselves expediently.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 1(3)(b) in Standard 1 Consumer dignity and choice.

**Requirement 1(3)(e)** - was found non-compliant following a Quality Audit undertaken from 20 August 2024 to 30 August 2024. The service did not demonstrate:

* Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice

The Assessment Team was not satisfied the provider could demonstrate that pertinent information regarding the timeframe for the delivery of care and services is communicated clearly and at the right time to allow consumers/representatives to make informed decisions. The Assessment Team provided the following evidence to support their assessment:

* Review of the consumer information pack and the client home care package agreement evidenced no information is provided to consumers/representatives within this documentation regarding the communication policy.
  + Management and staff advised of the organisation’s policy which stipulates that consumers/representatives are not required to be contacted regarding changes to service times if the change falls one hour before or after the originally scheduled time.
* Documentation reviewed evidenced each consumer, or potential consumers are not provided all of the information they need at the right time in order to make informed choices about the services being offered.
  + Feedback was provided to upper management who advised communication of this policy is communicated through the ‘care plan summary’ conducted in conjunction with the consumer’s care plan.
  + Management confirmed this is not communicated until after the consumer/representative has signed the service agreement with the provider.
  + Management acknowledged this information is not communicated to consumers at the right time and there would be a review of where and how this information would be communicated.

The Provider provided the following in response to the Assessment Team’s report.

* Time frames for service delivery is also recorded on client care summaries.
* Review these documents in order to make service delivery timeframes clear and communicated to consumers and their representatives. The incorporation of this information regarding service timeframes will also be incorporated into “Welcome Packs” so that this is clear to prospective future clients.
* The documents will state that visits will have a regular service timeframe, which will be within a “window” of 30 minutes to allow for minor delays. If, due to extended delays or unexpected leave, staff cannot attend within that timeframe, office-based staff will contact the client and advise them of any delays and ask if they wish for the service to continue.
  + This was evidenced in provided attachment ‘CC 087 – Scheduling – Community Care - Communicating Changes to Visits to Clients’, highlighting identified 30 minute “window”.
  + Further evidenced in ‘Scheduling - Community Care - contact clients where there are changes’ staff guidance.
* The provision of refresher training will be provided to staff that undertake client intake / admission and client review processes, also with our scheduling staff that assign staff to client services. That training will focus on client choice regarding service times.
* Attached document in regard to clients’ rights, timing of services and communication that were tabled at recent Consumer Advisory Body. At that meeting, we sought consumer feedback on the rights and responsibilities and how we can best communicate that information with our client group. This information also advises that we will have to prioritise services for clients based on their assessed need. You will note from the minutes, that the advisory body members were supportive of our approach.
  + Evidenced ‘Minutes for the Meeting of Consumer Advisory Body – Community Care 26 March 2024’ identifies under Feedback, Compliments and Complaints 2023 ‘It has been identified that the trend around complaints include issues such as Late arrivals for scheduled services, cutting services short and the communication of changes to services.
* CIP identifies Inconsistent communication with clients regarding time windows for services, and inconsistent approach to advising clients of time changes, with the following planned actions and expected due dates:
  + Review client information packs and care summary. (27 September 2024)
  + Communication strategy for clients regarding changes to services to be incorporated into client packs for discussion at admission and review. (18 October 2024)
  + Development of dedicated Scheduling Business Rule outlining organisational requirements for scheduling visits for clients and changes to schedules. (4 October 2024)
  + Refresher training to be delivered to staff completing intake and review and schedulers regarding client choice regarding service times. (11 November 2024)
* CIP further identifies a number of staff were unable to identify communication pathways available for clients, with the following planned action and outcomes:
  + Action - Information on available communication options for clients to be made available on Community Care SharePoint.
  + Outcome - Information for communication options available for clients has been made available via the Community Care SharePoint site. (Completed 13 September 2024)

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response. Whilst I acknowledge the Provider has responded to some of the deficiencies, I note that proposals within the CIP are yet to be completed and embedded, including.

* Communication strategy for clients regarding changes to services to be incorporated into client packs for discussion at admission and review. (Current progress 27 September 2024 Under review and scheduled for review at Consumer Advisory Body)
* Refresher training to be delivered to staff completing intake and review and schedulers regarding client choice regarding service times. (Current progress 27 September 2024 Training Session Plan drafted awaiting completion of Business Rule)
* Minutes for the Meeting of Consumer Advisory Body – Community Care 26 March 2024, *standing item*, identifies under Feedback, Compliments and Complaints 2023 ‘It has been identified that the trend around complaints include issues such as Late arrivals for scheduled services, cutting services short and the communication of changes to services.
  + I note that under Actions, Person Responsible, and Date to be Completed, fields were left unpopulated.
* The CIP captured this as an area of concern 29 August 2024, following it’s identification by the Assessment Team, over 6 months since it was initially identified at the meeting of Consumer Advisory Body.

The intent of this requirement is to ensure timely and easily understood information vital for consumers to be able to make informed choices is provided. It’s expected that organisations communicate clearly and supply helpful resources about their care and services, including the care and services they offer, commitments and obligations.

I appreciate the provider’s response regarding identified deficiencies and proposed timeframes in responding to them, however at the time of my finding, the full suite of proposed CIP actions have not been implemented or embedded. Once established and embedded, results should identify themselves expediently.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 1(3)(e) in Standard 1 Consumer dignity and choice.

**Requirements** **1(3)(a), 1(3)(c), 1(3)(d), and 1(3)(f)**

Consumers and representatives stated consumers are treated with respect by staff. Staff described how they treat consumers with dignity and respect. Documentation showed detailed recognition of consumers’ identity, culture and diversity, with each consumer’s background, social, cultural, language and family composition recorded.

Consumers and representatives confirmed the service supports consumers to exercise choice and independence, with staff ensuring the consumer is provided opportunities to decide on services and care provided. Staff described how they support consumers to make day-to-day choices. Management discussed how the service has ongoing discussion with consumers to support consumer choice and independence. Documentation showed the service captures details about whom the consumers wish to be involved in decisions.

Consumers and representatives confirmed consumers feel confident to take risks around mobilising in the community. Staff confirmed they encourage consumers to undertake challenging tasks. Documentation showed the service has a dignity of risk procedure and waiver process for consumers undertaking higher risk activities.

Consumers and representatives confirmed staff respect and protect the consumer’s privacy. Staff described how they maintain consumer privacy and confidentiality by not sharing information with others who are not authorised to receive it. Management described the process for sharing personal and sensitive information only with those who require the information. Documentation confirmed the service uses a privacy consent process prior to sharing information with others.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements 1(3)(a), 1(3)(c), 1(3)(d), and 1(3)(f) in Standard 1, Consumer dignity and choice.

# Standard 2

|  |  |  |  |
| --- | --- | --- | --- |
| Ongoing assessment and planning with consumers | | HCP | CHSP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant | Compliant |

Findings

Consumers and representatives confirmed assessment and care planning occurs. Care planning documentation showed assessment and planning considers risks to consumer health and well-being. The service uses validated tools to assess risks to guide the delivery of safe and effective care and services. Risks assessed include falls, pain, wounds and cognition. Staff confirmed they have access to care planning documentation to guide them on the care and services provided.

Consumers and representatives confirmed assessment and planning outcomes are reflective of what is important to the consumer to meet their needs and goals. Staff demonstrated awareness of what is important to each consumer, including the consumer’s needs and preferences for care. Staff and management described how assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and (palliative) end of life planning if the consumer wishes. Management explained care planning documentation is updated regularly based on ongoing assessment and planning processes. Documentation showed clear directives for staff to support the consumer based on the consumer’s assessed needs and goals.

Consumers and representatives confirmed the service involves them, and others they wish involved, in the care planning and assessment process. Staff and management demonstrated how assessment and planning occurs in partnership with consumers, the service and other health care professionals where necessary. Documentation showed assessment and planning involves the consumer and others the consumer agrees to be involved, including other organisations, individuals and other providers.

Consumers and representatives confirmed they receive assessment and care planning information and documentation, and staff know what they are doing. Staff confirmed they have access to care planning documentation to guide the care and services they provide for consumers. Documentation showed staff at the social support groups have access to clear directives in care plans to support consumers with their interests, likes, dislikes and medical conditions and HCP care plans have clear directives for staff.

Staff confirmed they receive access to updated care plans when services change with clear directives included. Management described how care is formally reviewed at regular intervals and when circumstances change or when incidents occur. Documentation showed regular reviews are conducted. Management advised they will ensure it is clearly documented new and updated care plans are provided to consumers.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 2, Ongoing assessment and planning with consumers.

# Standard 3

|  |  |  |  |
| --- | --- | --- | --- |
| Personal care and clinical care | | HCP | CHSP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant | Compliant |

Findings

Consumers and representatives confirmed consumers receive quality personal care. Staff were knowledgeable of each consumer’s unique needs and preferences. Management described how personal care is tailored to the needs of the consumer to optimise the consumer’s health and well-being. Documentation showed care directives clearly guide staff in how to provide personal care.

Staff described how they provide care for vulnerable and high need consumers and how they manage risks during service delivery. Management described how high-impact and high-prevalence risks are identified and how staff are provided with directives on how the support those consumers. Documentation showed strategies in place to guide staff in provision of care where high-impact or high-prevalence risks have been identified.

Consumers and representatives confirmed discussions about end-of-life planning are held. Staff and management described strategies for maximising consumer comfort when a consumer is nearing end of life. Documentation showed the service has procedures to prioritise services and onward referrals for consumers nearing end of life.

Consumers and representatives expressed confidence in staff being able to recognise and respond to a change in the consumer’s condition. Staff described how they would identify deterioration and how the service would adjust service delivery to meet the changed needs of the consumer. Management and staff have received training in recognising and responding to deterioration. The service uses a deterioration assessment tool which enables staff and management to identify, record and report signs and symptoms of deterioration.

Consumers and representatives expressed satisfaction that the consumer’s condition, needs and preferences are communicated within the service and with others where care is shared. Staff confirmed they have access to the consumer’s care directives through an application on their mobile device. Management discussed how information and recommendations to other health practitioners are received, reviewed and implemented and documented. Documentation showed the service communicates with others to ensure the provision of personal and clinical care for consumers.

Consumers and representatives expressed satisfaction the service will refer the consumer to other organisations and providers when required. Management demonstrated an understanding of referral networks and described internal and external referral processes used by the service. Documentation showed the service makes referrals to other organisations and providers where the need is identified.

Consumers and representatives confirmed staff use personal protective equipment when providing care and services. Staff stated they have completed infection control training to minimise infection. Management advised all staff have completed infection control training and staff have access to personal protective equipment. Documentation showed the service has an emergency management plan inclusive of infection control and outbreak plans.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 3, Personal care and clinical care.

# Standard 4

|  |  |  |  |
| --- | --- | --- | --- |
| Services and supports for daily living | | HCP | CHSP |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant | Compliant |

Findings

Consumers and representatives confirmed the services and supports for daily living the consumers receive support the consumers to optimise their independence and well-being. Staff described how individualised and effective services and supports for daily living meet each consumer’s needs, goals and preferences. Management stated feedback from consumers on activities would be part of the service’s activities calendar. Documentation showed assessments and care plans identify services and supports for daily living which promote individual consumer’s independence and enhanced quality of life.

Consumers and representatives expressed satisfaction with the supports for daily living received by consumers. Staff described how they recognise and support consumers’ emotional, spiritual and psychological well-being and how services provided meet those needs. Management demonstrated an understanding of supporting consumers in their emotional, spiritual and psychological well-being. Documentation showed evidence of support strategies to meet individual consumer’s emotional, spiritual and psychological well-being.

Consumers and representatives confirmed consumers participate in activities of interest to them in their homes and in the community. Staff stated they access information about consumers on the mobile application to guide them on how to support the consumer in their personal relationships. Management described processes used by the service to meet the social and personal needs of consumers. Documentation showed services and supports for daily living support consumers to participate in the community, do things of interest to them and have social and personal relationships.

Consumers and representatives confirmed the consumer’s needs and preferences are communicated during the assessment process. Staff confirmed they have access to each consumer’s needs and preferences through a mobile application. Management advised consumer care plans are available to staff through a mobile application and to subcontracted services through a service request process. Documentation showed care plans include clear directives about the consumer’s condition, needs and preferences.

Consumers and representatives confirmed the service supports consumers to access other services, including other lifestyle services where appropriate. Staff stated they will document concerns about consumers for management to review and make referrals where necessary. Management discussed processes used to refer consumers for additional care and higher-level packages. Documentation demonstrated the service refers consumers to organisations and providers for additional services and supports when necessary.

Consumers confirmed the food provided is satisfying and nutritious. Staff described how the service ensures appropriate meals are provided based on consumer needs and preferences, including allergies and likes and dislikes. Documentation showed the service has a documented emergency plan which identifies allergies, likes and dislikes of consumers and there are special directives for consumers with diabetes.

Consumers and representatives confirmed consumers have received equipment, which is safe, and suitable. Management described the assessment and ongoing processes to ensure equipment provided is suitable and safe for the consumer. Management stated equipment is checked at reassessment and will be serviced or replaced as necessary. Documentation showed equipment is selected for safety and suitability on the recommendations of allied health professionals.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 4, Services and supports for daily living.

# Standard 5

|  |  |  |  |
| --- | --- | --- | --- |
| Organisation’s service environment | | HCP | CHSP |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant | Compliant |

Findings

Consumers confirmed they feel comfortable and welcome in the service environments. Staff described how they support consumers to interact and use the service environment to suit their needs. Management described how they know consumers feel welcome by assessing attendance and participation in activities. Consumers were observed participating in activities in the service environment.

The service environment was observed to be clean, accessible and fit for purpose. Staff stated the environment is rearranged for the needs of consumers on the day and there is a cleaning process in place to ensure the environment is clean and ready for use by the consumers.

Staff and management described the processes for cleaning equipment and escalating issues with furniture. The service environment was observed to be clean and well-maintained.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 5, Organisation’s service environment.

# Standard 6

|  |  |  |  |
| --- | --- | --- | --- |
| Feedback and complaints | | HCP | CHSP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant | Not Compliant |

Findings

**Requirement 6(3)(c)** - was found non-compliant following a Quality Audit undertaken from 20 August 2024 to 30 August 2024. The service did not demonstrate:

* Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

The Assessment Team was not satisfied the Provider responded appropriately or promptly in response to feedback or complaints. Not all staff could describe how open disclosure process is applied, and how to communicate with consumers regarding complaints. Evidence indicates issues identified are systemic across all services due to staff not being supported to handle complaints or proactively apply the elements of open disclosure in response to a complaint. The Assessment Team provided the following evidence to support their assessment:

* Review of documentation evidenced the complaints handling process in line with an open disclosure approach was not applied or documented in all instances.
* Management and staff interviews supplemented by documentation review evidenced staff are not provided adequate training and resources to meet this Requirement.
* Documentation reviewed evidenced one consumer lodged a complaint on 12 April 2024 regarding receiving different staff for services on 4 different occasions. Documentation and discussion with management demonstrated the consumer did not receive communication of the outcome of the complaint in a timely manner.
  + A progress note dated 19 June 2024 demonstrated a general check in phone call with the consumer where preferred staff were discussed.
* One consumers representative said after receiving an over toilet chair, the representative was not satisfied that it was suitable. The representative said they returned the equipment however were not satisfied as the consumer did not receive a refund for the returned equipment.
  + Review of correspondence evidenced the representative requesting a refund for the equipment, with acknowledge from the Occupational Therapist on 31 May 2024.
  + However, documentation evidenced no further communication was provided to the representative regarding this matter until 22 August 2024.
    - The Assessment Team acknowledges that when feedback was provided to management regarding the consumer and representative, both charges were reversed in reaction to the feedback. However, this approach was not taken until after feedback was raised by the Assessment Team.
* Management and staff advised there is no training provided regarding complaints handling and staff can seek guidance by referring to the organisation’s policies and procedures.
  + - Training records reviewed confirmed staff are not provided training in relation to the management of feedback and complaints

The Provider provided the following in response to the Assessment Team’s report.

* The provider has existing complaint management and handling business rules, and an incident management system (IMS) for the recording of that data. However, it is clear that the associated processes are not being universally applied, so our approach will be to retrain all staff in our systems and processes. Our training packages will be revised by the 25th of October 2024. CIP documents the following identified issues, and proposed actions and expected due dates.
  + Staff were unable to demonstrate their understanding of open disclosure or provide examples of the practice in use.
    - Review of training materials, business rules and processes relating to Open Disclosure principles including documentation within Ticket. (25 October 2024)
  + A number of complaints and feedback Ticket events also did not provide evidence of open disclosure principles being followed.
    - Refresher training to be delivered to all staff on Open Disclosure and documentation requirements. (31 December 2024)

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response. Whilst I acknowledge the Provider has responded to some of the deficiencies, I note that proposals within the CIP are yet to be completed and embedded in their entirety.

I further acknowledge staff interviewed and documentation evidenced displays areas in which the Provider is meeting aspects of this requirement, including consumers and representatives sampled indicating satisfaction with the actions taken and response provided in relation to feedback or complaints. Furthermore, the majority of staff sampled were able to describe a potential response to feedback or complaint in line with at least one element of the open disclosure framework and describe aspects of the complaints handling process. Additionally:

* Some complaints documentation reviewed evidenced actions and response in line with the open disclosure framework.
* The existing client engagement policy explains the complaints handling process, including escalation and timeframes.
* The consumer information pack was reviewed which evidenced consumers are provided information on the complaints management system.
* Management acknowledged the discrepancies in the complaints handling process including where staff had not documented outcomes or communication to the consumer and said this is an area for improvement. Review of the CIP evidenced the provider intends on reviewing the policies and procedures for open disclosure. Management stated these policies will continue to be the reference material for staff used as for training.

I have considered the above in conjunction with deficiencies identified by the Assessment Team which do not imply a systematic deficiency across all services. Though I acknowledge formal training is not provided, staff were able to extract elements of open disclosure and documenting outcomes and communication to consumers in their responses to the Assessment Team. This, when coupled with the expectation of training delivery and updates to guidance material suggests a positive direction for its implementation.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 6(3)(c) in Standard 6 Feedback and complaints.

**Requirement 6(3)(d)** - was found non-compliant following a Quality Audit undertaken from 20 August 2024 to 30 August 2024. The service did not demonstrate:

* Feedback and complaints are reviewed and used to improve the quality of care and services.

The Assessment Team was not satisfied the Provider could demonstrate there is a system in place which reviews feedback and complaints trends, nor escalates this information to inform quality improvements. The Assessment Team provided the following evidence to support their assessment:

* Management could speak to complaints trends evident in specific services, however they were unable to demonstrate how this information is reported to a member of the organisation with the authority to make change.
  + Documentation reviewed did not evidence consistent communication of this information or how feedback or complaints had been used to inform learning or quality improvements.
* Management interviewed stated they do not trend feedback and complaints data and confirmed the provider does not have a system which enables them to monitor, trend or report feedback and complaints.
  + A Review of the management’s monthly checklist between April 2024 and July 2024 demonstrated reports to senior management regarding the number of closed and overdue complaints. These documents did not evidence escalation of complaints trends.
* A Review of meeting minutes across 5 services between January 2024 and August 2024 evidenced feedback and complaints information was not communicated to staff or where information was communicated, there was no learnings mentioned or actions for continuous improvement.
* Identified core deficits across all services, with significant evidence identified in Service - 18280 Ozcare - Fraser Coast and Service - 23030 Ozcare Home Care Packages - Mackay Region. Review of the complaints register confirmed this complaint trend for the 2 services between January 2024 and June 2024.
  + Management advised they discussed this trend with service level management to filter down information to the workforce and remind them to refer to policies. Management was unable to provide evidence of when or how this conversation had taken place.
* A Review of staff meeting minutes for Service - 18280 Ozcare - Fraser Coast stated complaints are addressed with individual staff as they arise and did not demonstrate further discussion or improvements.
* Further review of staff meeting minutes for Service - 23030 Ozcare Home Care Packages - Mackay Region between January 2024 and August 2024 did not demonstrate any mention to feedback or complaints.
* A review of meeting minutes for Service - 23031 Ozcare Home Care Packages - North Lakes Region between March 2024 and August 2024 demonstrated inclusion of complaints received. However, did not demonstrate discussion of learnings, action taken, or improvements implemented.
* Management stated the provider takes a risk-based auditing approach where internal audits are conducted in areas where risk is identified, with a clinical focus.
* Internal audit documentation reviewed did not mention feedback or complaints data or what had triggered the internal audit.
* Management acknowledged there is currently limited to no trending or analysis of feedback and complaints. Management advised this had been added to the plan for continuous improvement, to review the system for trending feedback and complaints to include outcomes and actions. The Assessment Team sighted this item on the CIP with a planned completion date of 30 October 2024.

The Provider provided the following in response to the Assessment Team’s report.

* During the course of the Quality Audit, the Chairman on the Board spoke to how information regarding complaints and also client surveys was presented twice annually at Board meetings. However, we accept that at the service level, there is an opportunity to improve the trending and analysis of complaints with a view to improving service.
* We (The provider) have recently made available a series of reports to aid Branch Managers conduct this analysis. All Branches will be instructed to ensure that they are following our Business Rule, which articulates that client feedback and complaints is not only to be analysed, but those trends are also discussed at staff meetings so that staff are aware of the nature of complaints and what drives levels of client satisfaction. We intend to action these initiatives by 30 October 2024.
* The provider also notes that under Requirement 8(3)(a), the finding reference 3 specific improvements made based on feedback and complaints. These relate to food service, and bathroom layout as a consequence of client feedback, and complaints received in regard to a brokered service provider. This evidences that client complaints and feedback is being used to improve the quality of service provided.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response. Whilst I acknowledge the Provider has identified improvements based on feedback and complaints including relating to food service, bathroom layout, and complaints received in regard to a brokered service provider, these are isolated examples.

I further acknowledge that information regarding complaints and client surveys are presented twice annually at Board meetings, however the Provider self acknowledges the following:

* At the service level, there is an opportunity to improve the trending and analysis of complaints with a view to improving service.
* All Branches will be instructed to ensure that they are following our Business Rule, which articulates that client feedback and complaints is not only to be analysed, but those trends are also discussed at staff meetings so that staff are aware of the nature of complaints and what drives levels of client satisfaction. We intend to action these initiatives by 30 October 2024.

The intent of this requirement is to ensure the organisation has a best practice system to manage feedback and complaints. Organisations should use this system to improve how they deliver care and services. As well as encouraging complaints and asking for feedback, the organisation should provide timely feedback to the organisation’s governing body, its workforce and consumers on complaints and the actions the organisation took. It’s expected that the organisation will use information from complaints to make improvements to safety and quality systems and regularly review and improve how they manage complaints, on an ongoing basis.

From an organisational level:

* This is evidenced through ongoing monitoring of feedback and complaints.
* Evidenced that complaints are escalated so that they go to a member of the organisation with authority to make a change.
* Evidenced by how the organisation monitors, reports and keeps improving its performance against this requirement.

I have utilised information provided within the CIP under response to Standard 8, Requirement 8(3)(d) that further acknowledges on the part of the provider that this is an identified issue, documented as follows:

* Identified limited trending and analysis of feedback, complaints, incidents and high impact, high prevalence risks and the monitoring of this locally or organisationally.
* Planned action - Review of system and processes relating to trends and analysis, including process and outcome measures, and the associated actions required review processes for reporting trended information organisationally.
* Progress – 27 September 2024 Review of processes underway including communication pathways, at management and service level, for monitoring local trends in complaints, incidents and risks. Expected due date 30 October 2024.

I appreciate the provider’s response regarding identified deficiencies and proposed timeframes in responding to them, however at the time of my finding, these actions have not been implemented or embedded.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 6(3)(d) in Standard 6 Feedback and complaints.

**Requirement 6(3)(a) and 6(3)(b)**

Consumers and representatives confirmed they are aware of how to provide feedback and raise complaints and feel safe to do so. Staff stated they seek feedback from consumers during service delivery and emphasise to consumers the importance of making feedback. Management stated the complaint procedure is explained to consumers. Documentation showed complaint mechanisms and procedures are included in consumer agreements and consumer information manuals.

Consumers and representatives confirmed they are aware other methods for raising and resolving complaints, including knowing how to contact the Commission. Documentation showed the service’s complaints procedure and consumer manuals offer consumers diverse internal and external feedback, complaints and advocacy options.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements 6(3)(a) and 6(3)(b) in Standard 6, Feedback and complaints.

# Standard 7

|  |  |  |  |
| --- | --- | --- | --- |
| Human resources | | HCP | CHSP |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant | Compliant |

Findings

**Requirement 7(3)(a)** - was found non-compliant following a Quality Audit undertaken from 20 August 2024 to 30 August 2024. The service did not demonstrate:

* The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. These deficiencies were related to the following Home care Package Service 18280 Ozcare - Fraser Coast.

The Assessment Team was not satisfied staffing allocations adequately meet consumer needs and ensure the delivery of safe and quality care and services. The Assessment Team provided the following evidence to support their assessment:

* Consumer and representative interviews highlighted that, due to staffing deficits, there is a limited choice regarding when they want care and services delivered. Additionally, consumers and representatives said there is a lack of consistency with staffing.
  + One consumer observed that different staff members arrive at the front door each time, and their identities are not always clear beyond their Oz Care uniforms.
  + One consumer representative reported that due to staffing shortages, the service frequently changes the times of scheduled social support outings. The representative further said although the service provides advance notice of these changes, it happens very often.

The Provider provided the following in response to the Assessment Team’s report.

* Updated business rule make our organisational position and expectation clear. (Scheduling - Community Care - contact clients where there are changes).
  + In regard to staff that our clients have advised they do not want to receive services from. In our electronic client management system, we utilise a “Do Not Send” register for the purposes of recording details of staff that our clients have advised us to refrain from sending to their home.
  + The service has a number of clients that have asked us to assign a particular staff member to their service. One issue we must manage is that some staff have been requested by multiple clients, but they can only provide support to one client at a time. In such instances, we have advised that we may be able to assign the staff member, but that they may have to arrive at the time that the client does not prefer. In such instances, the client makes the choice for their preference.
* Contemporaneous research on the benefits of clients receiving their services from multiple staff.
* This requirement was considered not met for Home Care Packages but met for Commonwealth Home Support Packages.
  + The Provider would like to advise that our staff rostering practices are identical for HCP and CHSP.

Additionally, the following responses were provided to the Assessment Team regarding identified impacts to service delivery.

* Scheduling staff and management have confirmed there is a staffing deficit; however, they have implemented the following initiatives to ensure shifts are covered and continuity of care and services is maintained:
* The service has a casual pool and brokered staff for replacement which includes care staff, home support staff, and Registered Nurses.
* Management confirmed the service is currently advertising the role of Community care worker (which was sighted by the Assessment Team).
* Scheduling staff confirmed and review of schedules demonstrated how the service staff are allocated and replaced to provide the agreed care and services.
  + The scheduling staff explained the shifts are prioritised with medications first and cleaning last.
* Review of roster and staff interviews confirm, on weekends, personal care and medications are managed by an on-call scheduling staff who manages replacements to ensure continuity of care.
* Management said they do not accept new consumers if they are unable to fully meet their care and service needs.
  + The Assessment Team sighted the branch manager and operations manager checklists which indicates these discussions around service’s ability to intake new consumers occur each month.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response, both within the Assessment report, and within their right of reply.

I acknowledge the Provider had self-identified deficiencies impacting aspects of service delivery and had already introduced measures to respond to some of these deficiencies, including advertising the role of a Community care worker which was sighted by the Assessment Team. Additionally, Management said they do not accept new consumers if they are unable to fully meet their care and service needs.

The Assessment Team sighted the branch manager and operations manager checklists which indicates these discussions around the service’s ability to intake new consumers occur each month. This measure once again, implies the Provider is conscious of staffing impacts and consistency, and understands the ramifications of increasing consumer client intakes, without having sufficient staffing arrangements in place to deliver services as required.

Furthermore, the prioritising of potential risk impacted service delivery is prioritised with scheduling staff explaining that shifts are prioritised with medications first, and cleaning last.

I finally note that the deficiencies identified were isolated to a specific service, rather than systemic across all service delivery. This is significant when read in conjunction with staff rostering practices being identical for HCP and CHSP.

The intent of this requirement expects organisations to have a system to work out workforce numbers and the range of skills they need to meet consumers’ needs and deliver safe and quality care and services at all times. The system for managing the workforce may be different for each type of care and service. It’s expected that an organisation uses a structured approach for rosters and schedules, hiring and keeping members of the workforce, managing different types of leave and the use of contracted staff.

Regularly reviewing workforce levels and their mix of skills is expected. This includes adapting these levels to respond to the changing needs and situations of consumers. As part of this, organisations need to manage growth and changes in workforce needs.

The organisation’s approach is expected to include ways to promptly identify and manage issues and risks that might result in not having enough members of the workforce. They also need to anticipate and think about ways to deal with shortages across the workforce.

In addition to having enough staff to deliver the usual work of the organisation, it is expected that the organisation will have considered its staffing needs during internal or external emergencies.

It is noted within the examples provided in the Assessment Team Report to support a finding of not met, consumers sampled identified they still receive care and services to meet their needs, though continuity of care and services for consumers is impacted by inconstancies. Moreover, of those consumers sampled and evidenced as both met and not met, none had experienced cancelled shifts, nor was risk identified.

The Provider is meeting aspects of this requirement and identified deficiencies and proposed solutions had been determined prior to the Assessment. Importantly, as per the intent of the requirement, the provider is addressing these deficiencies with alternative response mechanisms where they can. On weight of evidence, I believe the steps being taken to address these remaining impacts to service delivery show a willingness to respond and ensure consumers receive safe and quality care and services.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 7(3)(a) in Standard 7, Human resources.

**Requirements 7(3)(b), 7(3)(c), 7(3)(d), and 7(3)(e)**

Consumers and representatives confirmed consumers feel respected. Staff described how they relate to consumers respectfully.

Consumers stated staff are competent. Staff described the minimum qualifications required for their roles. Management described the service’s processes for determining staff competency, including for subcontracted staff. Documentation showed evidence of minimum qualifications and knowledge required for each role.

Staff confirmed they receive induction training and ongoing mandatory training. Management explained and documentation review confirmed staff receive ongoing training and support through staff meetings and via an online learning portal, where training is delivered when necessary.

Support staff confirmed they undergo regular informal performance appraisal processes with management. Management confirmed support staff undergo regular informal performance appraisal processes with office staff undergoing formal annual appraisal processes. Management stated a review of performance appraisal processes will be undertaken. Documentation showed evidence of performance reviews being completed for office staff.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 7, Human resources.

# Standard 8

|  |  |  |  |
| --- | --- | --- | --- |
| Organisational governance | | HCP | CHSP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Not Compliant | Not Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Not Compliant | Not Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Not Compliant | Not Compliant |

Findings

**Requirement 8(3)(b)** - was found non-compliant following a Quality Audit undertaken from 20 August 2024 to 30 August 2024. The service did not demonstrate:

* The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

The Assessment Team was not satisfied that the board receives incident and complaint trends. The Assessment Team provided the following evidence to support their assessment:

* Management interviewed, and documentation reviewed confirmed the provider is not currently trending all incidents such as falls, skin tears and near misses within community care setting.
* Whilst all complaints and feedback are recorded in the electronic case management system, the trends are not documented and provided to management by each service and as a result, these trends are not presented to the board to review.
* Management acknowledged this deficit and advised the enhancements in clinical reporting and existing processes will occur as part of their initiatives aimed at improving the tracking and analysis of incidents, complaints, and feedback.

The Provider provided the following in response to the Assessment Team’s report.

* Advisement that the Board does receive reports on client complaint trends, and client surveys.
  + This data is tabled twice per annum at Board meetings based on an annual workplan that the Board has established to ensure they meet their obligations.
  + Supporting evidence included (Clinical Care & Oversight Committee (CC&O Committee - Extract from Minutes 16 May 2024) containing:
    - 10. Client Experience Surveys
    - 10.1 Community Care - Voice of the Customer
    - 10.2 Aged Care - Client Satisfaction Surveys
    - 11. Quality Care Advisory Body (QCAB) Update
    - 11.1 QCAB Aged Care Report - May 2024
    - 11.2 QCAB Community Care Report - May 2024
* Additionally, a new incident classification and recording system is now “live” in the IMS. This system will allow for the capture of incident data, it’s trending and analysis and will from part of our governance practices at the site level, but also organisationally. The reports will be included in the other incident reports provided to our Board.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response, both within the Assessment report, and within their right of reply.

The intent of this requirement states the governing body of the organisation is responsible for promoting a culture of safe, inclusive and quality, care and services in the organisation. The governing body of the organisation is also responsible for overseeing the organisation’s strategic direction and policies for delivering care to meet the Quality Standards.

I have utilised evidence provided, including information provided to the Board including relevant details to enable the monitoring of safe and effective services, including but not limited to the following: Consumer experience survey results, Staffing levels and training requirements for staff, Internal clinical and care audit results, Updates to policies and procedures, External regulatory bodies, and Trending for medication incidents and SIRS.

I also note that the assessment team acknowledge that the board promotes a culture of safe, inclusive, and quality care and are accountable for its delivery. Overwhelming evidence within the assessment report supports the governing body is committed to, and leads, a culture of safety and quality improvement in the organisation. The Board is informed of the providers operations through regular meetings and reports and can also describe how the governing body tries to understand how things are done in the organisation.

The provider has an established Risk and Audit Committee dedicated to conducting internal audits and identifying areas for improvement.

The board outlined and the assessment team viewed the formal reports which provide them with the necessary information for decision-making and maintaining oversight of the provider’s performance, regulatory compliance and workforce information and training. The Assessment Team sighted board meeting minutes including results of internal audits of the Townsville (23035) community and Townsville day respite services highlighting areas needing improvement, such as wound care plans, emphasis on sharing findings across branches for learning.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 8(3)(b) in Standard 8, Organisational governance.

**Requirement 8(3)(c)** - was found non-compliant following a Quality Audit undertaken from 20 August 2024 to 30 August 2024. The service did not demonstrate:

* Effective organisation wide governance systems relating to continuous improvement and feedback and complaints.

The Assessment Team was not satisfied feedback trends are not uniformly tracked, as outlined in Standard 6 Requirement 6(3)(d), this inconsistency prevents effective integration of consumer feedback and complaints into the statewide CIP resulting in limits in the providers ability to identify and capitalise on continuous improvements. The Assessment Team provided the following evidence to support their assessment:

* Three items in the Statewide CIP have exceeded their expected completion dates, however, the progress and completion dates for these items have not been recorded.
* Two items identified in the Statewide CIP do not have an expected due date recorded.
* The system does not support trending, and trends are verbally handed over to higher management.
* The policy and procedures guiding complaints management do not incorporate open disclosure. Additionally, the Assessment Team found feedback and complaints data are not consistently trended or utilised effectively for making improvements

The Provider provided the following in response to the Assessment Team’s report.

* In this requirement, it was identified that we did not demonstrate the requirement was met in its entirety. The deficiency related to continuous improvement and feedback and complaints.
* The provider has initiated process to improve staff awareness of restrictive practices, open disclosure, and cultural safety. We believe these particular aspects have been addressed in the response to other requirements above and below.
* With the incorporation of all complaints and feedback data into our IMS, we will have enhanced ability to trend and analyse that data for the purpose of quality improvement.

The intent of this requirement is about how the organisation applies and controls authority below the level of the governing body. Authority flows from the governing body to the Chief Executive Officer (or similar role), then, to the executive or management team and throughout the organisation. This requirement lists the key areas that an organisation needs for effective organisation wide governance systems. These systems should take into account the size and structure of the organisation. They should also help to improve outcomes for consumers.

Continuous improvement systems and processes assess, monitor, and improve the quality and safety of the care and services provided by the organisation. This includes the experiences of consumers. These systems help the organisation to identify where quality and safety is at risk. They also help an organisation to respond appropriately and promptly to these risks. Organisations must have a plan for continuous improvement and check their progress against this plan to improve the quality and safety of care services.

Feedback and complaints systems and processes actively look to improve results for consumers. The system used is relevant and proportionate to the range and complexity of care and services the organisation delivers, as well as its size and scale. The system follows principles of transparency, procedural fairness, and natural justice and meets best practice guidelines.

As per Requirement 6(3)(d), The Assessment Team was not satisfied the Provider could demonstrate there is a system in place which reviews feedback and complaints trends, nor escalates this information to inform quality continuous improvements. However it was identified that the provider has effective organisation wide governance systems relating to information management, financial governance, workforce governance, including the assignment of clear responsibilities and accountabilities, and regulatory compliance.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response. Whilst I acknowledge the Provider has identified improvements based on feedback and complaints to drive continuous improvement with the incorporation of all complaints and feedback data into their IMS, resulting in enhanced ability to trend and analyse that data for the purpose of quality improvement, at this stage they are not fully embedded.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 8(3)(c) in Standard 8, Organisational governance.

**Requirement 8(3)(d)** - was found non-compliant following a Quality Audit undertaken from 20 August 2024 to 30 August 2024. The service did not demonstrate:

* Effective risk management systems in relation to high-impact and high-prevalence risks and incident management systems.

The Assessment Team was not satisfied the provider had effective risk management systems in relation to managing high-impact or high-prevalence risks associated with the care of consumers and managing and preventing incidents, including the use of an incident management. The Assessment Team provided the following evidence to support their assessment:

* Management interviews and documentation review revealed that the services are not maintaining a vulnerable consumer register, which could aid services in identifying consumers at high risk.
* The absence of trend analysis within documentation for incidents such as falls, skin tears, and near misses limits the providers ability to manage high-prevalence, high-impact risks effectively. Without this analysis, the provider did not demonstrate the ability to implement proactive, preventative strategies and instead relies on a reactive approach that addresses issues only after they occur.
* Documentation review confirmed the incident register provided by the provider for the period from January 2024 till August 2024 did not have all incidents recorded.

The Provider provided the following in response to the Assessment Team’s report.

* Documented stating the finding stated that Ozcare does not have a vulnerable consumer register. That finding is incorrect. We have both a Business Rule for that process, and also a specific field in our electronic client management system (it is named “at risk in an emergency”) for the recording of that data. This functionality was used a few years ago during the Bundaberg flooding event – during that natural disaster, we used the function in order to identify clients who might be at risk, and to then contact those individuals to determine if they had all the medication, food etc they would need for the duration of the natural disaster.
* Documented acceptance regarding the deficiency in the recording of incidents such as falls, skin tears etc, while capturing other incident data such as medication, SIRS etc.
  + During the course of the Quality Audit, we showed the Lead Auditor the process we are developing in our IMS for the recording of such events. We have now activated that system and anticipate that data will start being collected shortly. The data collection will join the other incident information used for governance purposes and for Board level reporting.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response. I acknowledge the Provider has identified improvements within their IMS. The following was extracted from the assessment report.

* Review of ‘Ticket’ revealed a new incident reporting form was designed by provider. The Assessment Team reviewed the form, it includes a function to record falls, skin tears, near misses, and acute events such as hospitalisations, pain, and confusion.
  + Management confirmed and documentation review revealed medication incident and SIRS are logged into electronic system while other incidents such as falls, skin tears or near misses are recorded in progress notes in the ECMS.
* Management interviews and documentation review confirmed the new form will be rolled out in the 'Ticket' system by end of September 2024 and made accessible to all staff, and this will remain in use until the introduction of the new the ECMS in June 2025.
* The following was considered within the Providers CIP:
  + Identified issue - 19 September 2024 - Identified need for improvement relating to recording, management and trending of client incidents
  + Planned action - New Incident category to be created within IMS. Intended use, definitions of sub-categories for the new type and the interaction with the Procura client record to be documented in Business Rules. Develop training material for implementation of new incident category and related workflows within IMS. Processes for monitoring the use of the client incident category to be developed and embedded in practice. Training to be conducted with all Community Care staff on client incident reporting requirements and monitoring workflows.
  + Expected due date – 30 September to 29 November 2024.

I further acknowledge that the Assessment Team recognised that, while incidents were not trended or analysed, consumer interviews and progress notes confirm they were addressed to ensure that any potential impact on consumers was effectively managed and mitigated. I further recognise it was identified that the provider has effective risk management systems and practices relating to identifying and responding to abuse and neglect of consumers and supporting consumers to live the best life they can.

The intent of this requirement is to ensure organisations have systems and processes that help them identify and assess risks to the health, safety and well-being of consumers. If risks are found, organisations are expected to find ways to reduce or remove the risks in a timeframe that matches the level of risk and how it’s affecting consumers.

It’s expected that the organisation’s risk management system identifies and evaluates incidents and ‘near misses’ (both clinical incidents and incidents in delivering care and services). A near miss is when an occurrence, event or omission happens that does not result in harm (such as injury, illness or danger to health) to a consumer or another person but had potential to do so. It’s also expected that the organisation uses this information to improve its performance and how it delivers quality care and services.

Organisations are expected to escalate risks to the health, safety and well-being of their consumers within the organisation or to a relevant external service or organisation. It’s also expected that organisations continue to monitor risks to consumers and others and take action if a risk has increased. While organisations need to manage all risks related to care and services, some risks are more common and have a higher impact on the health and well-being of consumers.

Organisations are expected to effectively prevent and manage incidents, including through the use of an IMS that enables incidents to be identified, responded to, and notified to the Commission (as required). Incidents should be resolved in consultation with consumers and staff, and incident data should be used to identify trends, drive continuous improvement to improve the quality of the care and services, and prevent similar incidents from occurring.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response. Whilst I acknowledge the Provider has identified improvements based on feedback from the Assessment team and made concerted efforts to introduce a draft of measures to respond to both incident management and high-impact or high-prevalence risks associated with the care of consumers, at this stage they are not fully embedded.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 8(3)(d) in Standard 8, Organisational governance.

**Requirement 8(3)(e)** - was found non-compliant following a Quality Audit undertaken from 20 August 2024 to 30 August 2024. The service did not demonstrate:

* Where clinical care is provided - a clinical governance framework relating to minimising the use of restraint.

The Assessment Team was not satisfied the provider could demonstrate adequate oversight in relation to restrictive practices in community. However, I recognise the provider has frameworks relating to antimicrobial stewardship and open disclosure. The Assessment Team provided the following evidence to support their assessment of minimising use of restraint:

* Though the provider has established restrictive practice policies for residential aged care and hospital settings, there is currently no restrictive practice policy or training to guide staff in identifying and reporting various forms of restraints in home care settings.
  + Management-level staff asserted that restrictive practices are applicable only in residential aged care settings, not in home services settings.
  + While medication lists are recorded, evidence viewed identified the provider does not currently analyse to identify psychotropic medications or chemical restraints for consumers receiving medication support.
  + The provider's self-assessment summary dated June 30, 2024, indicates that no restraints are used in the community setting.
    - However, the Assessment Team identified that bed rails are used in the community setting.
    - The Assessment Team acknowledges these instances and confirms that OT assessments were conducted, and consent was appropriately sought for the use of bed rails. However, the provider could not demonstrate knowledge of restrictive practices being used in the community setting.
* Management acknowledged the deficit identified by the Assessment Team and added improvement items to CIP to establish clear guidelines for the use of restrictive practices in community settings. The following CIP items were sighted by the Assessment Team:
  + Identifying, reviewing, and documenting all forms of restrictive practices currently used or encountered within Community Care services by 4 October 2024.
  + Developing policy for restrictive practices in both home care and day respite settings by 4 October 2024.

The Provider provided the following in response to the Assessment Team’s report.

* It was identified that Ozcare has a restrictive practice guidance and Business Rules, but that these are primarily focused on residential aged care, and that there was no policy or training to guide staff in the community setting.
* We accept this finding and are developing a distinct Business Rule that will apply only in our community care setting and provide examples of what restrictive practices could be particularly in the community care setting.
* This will be completed by the 30th of October 2024. Further, we will train staff to identify and document all forms of restrictive practice that might be used (including those by clients and their family) at the client intake stage – this will be completed by 29 November 2024.
* Finally, we will have trained all staff in recognising restrictive practices by 31 December 2024.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response (reflected in their CIP). I acknowledge the Provider has self-identified current deficiencies and proposed improvements and dates of introduction. However, at the time of my finding, these actions have not been fully implemented or embedded.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 8(3)(e) in Standard 8, Organisational governance.

**Requirements 8(3)(a)** - The Provider seeks feedback including through the consumer advisory body, member experience surveys, assessment and care planning reviews and promoting an overall culture which encourages feedback and complaints. Consumers are provided newsletters to keep them informed of changes in Aged Care.

1. The preparation of the performance report is in accordance with section 57 of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)